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January 26, 2000

Jennifer Nichols
Prudential Insurance Company of America
Disability Management Services
P.O. Box 2300
Parsippany, NJ 07054

RE: Eric Jeffries
Control Number/Br: 37212/00001
Claim Number: 99-074-0184

Dear Ms. Nichols.

This is a report on an independent medical file review on a claimant, Eric Jeffries, who has been out of work since September 26, 1998 because of his illness. This claimant is applying for a long term disability benefit under a group policy that was issued to his employer, The Provident Bank. Total disability can exist when all of the required conditions are met:

A. when the claimant is unable to perform the duties of his occupation
B. after a period of disability he is not able to perform any job for which he is reasonably fitted by his education and experience

The claimant must be under the regular care of a doctor and must not be working at a job for wage or profit

You asked after a chart review that my report would answer the following questions:

1. Is there medical evidence of a significant impairment in Mr. Jeffries?
2. Provide a review of the diagnostic test results.
3. Does the documentation support there was a significant change in Mr. Jeffries status pre- and post- September 1998 when he went out of work?
4. Does the medical documentation support there is a causal relationship between Mr. Jeffries symptoms and diagnosis of post vaccinal encephalomyelitis and acquired immunity?
5. Are there any discrepancies, inconsistency, or contradictions in the claimant's record?

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CASE HISTORY

Mr. Eric Jeffries is a 38 year old man who had been in generally very good health until he received and injection of vaccine for Hepatitis B, a viral infection. Following the injection, a few weeks later he became ill.

According to the affidavit of Mr. Jeffries he received an injection of the Hepatitis B vaccine in July of 1997. He became ill in days. He described his symptoms at that time as severe muscle pain, joint pain, headaches, abdominal pain, cognitive difficulties, rash, eyes swelling, disorientation and fatigue. Between June 1997 and September 1999 Mr. Jeffries pursued a diagnosis for treatment of his symptoms. He listed a partial chronology of his care in naming twenty-one different physicians that he visited. This included acupuncture treatment in May of 1999. The last physician Mr. Jeffries had seen, according to his chronology, was Dr. Waisbren in September 1999. The doctor gave a diagnosis of a post-vaccinal encephalomyelitis and acquired auto-immunity. The claimant has continued with his symptoms.

INQUIRIES

Is there medical evidence of a significant impairment in Mr. Jeffries?

The evidence for significant impairment in Mr. Jeffries is entirely subjective. By that I mean the debilitating pains and mental confusion he has experienced cannot be measured in any way other than the patient expressing this problem. There is no laboratory evidence to prove or disprove the fact he is having pain, or the fact he has some mental confusion and is unable to concentrate properly.

There is no objective evidence to support the diagnosis of generalized pain he experiences. This is in no way meant to discredit Mr. Jeffries.

Does the documentation support that there was a significant change in Mr. Jeffries' status pre- and post- September 1998 when he went out of work?

Reviewing the physical examinations of the attending physicians, before and after September of 1998, I cannot see any distinguishing difference. However, as I understand it, the reason Mr. Jeffries left work was because of the increasing pain and fear of not doing a good job at his work because of his questionable mental condition.

Does the medical documentation support that there is a causal relationship between Mr. Jeffries' symptoms and post-vaccinal encephalomyelitis and acquired auto-immunity?

The medical documentation does not support a definite causal relationship between the symptoms that Mr. Jeffries suffers and the diagnosis of post-vaccinal encephalomyelitis and acquired auto-immunity. But, it does not eliminate a causal relationship between symptoms and diagnosis. Mr. Jeffries' symptoms are cyclic, changing from time to time, increasing in severity from time to time, having a waxing and waning character. This is not unusual for any of the auto-immune problems.

Currently auto-immune diseases are diagnosed by elimination of all other known causes of the symptoms.

Are there any discrepancies, inconsistencies or contradictions in the claimant's records?

There are no contradictions in the claimant's records. There is a history common to many people with auto-immune diseases. Symptoms vary from time to time and are more severe from time to time. He is relatively consistent in that the pains are localized to any and all of these joints and muscles. The disease defies a firm diagnosis and is usually managed with the conservative care and symptomatic treatment. With time a more definitive diagnosis may be made. However, it is possible he may maintain these non-specific aches and pains and may defy a more definite diagnosis.

REVIEW OF DIAGNOSTIC TESTS

Diagnostic tests on Mr. Jeffries were performed in order to support a diagnosis and explanation of his ongoing problem.

Some of the pains were localized to the general area of the abdomen, specifically in the right upper quadrant. Therefore, a gallbladder study was ordered. He had an ultrasound of the gallbladder which was not diagnostic of cholecystitis. The diagnosis of irritable bowel syndrome was consideration, as was, Crohn's disease. An endoscopy study was performed. The claimant had an upper endoscopy at Bethesda North Hospital, which was normal. He later he had a colonoscopy done, which was reported as normal. The cause of the abdominal diagnosis remained undetermined. Serum ferritan and a CBC were within normal limits, as was the sedimentation rate and the reticular count. This ruled out any hemolytic type anemia which could cause an elevation in the bilirubin. He was considered to have Gilbert's disease, a congenital, benign liver problem.

An immunological disorder was considered due to the multiple joint complaints, and muscle complaints. The Complement series was evaluated and C3 and C4 were measured, as well as the CH100. The C3 and C4 were normal. The CH100 was in the low range. An ANA titer was obtained and found to be normal. The test for double stranded DNA was also normal.

A series of antibody studies including the SM, RNP, SSA/RO, SSB/RA, SCL70, and JO-1 were all normal.

Sedimentation rate remained within normal limits. A CEA antigen (indicative of carcinoma) was also normal. Keratin level was likewise within the normal range. Liver enzymes were normal except for ALT which was 48 U/L. This is clinically insignificant with the upper limit of normal being 46U/L. Total bilirubin was 1.2 which is slightly above the normal average. These values were obtained in February of 1999. The total complement level measured in February 1999(CH50) was 80 units, which is in the normal range. (Some laboratories measure the total complement calling the test CH50, while other laboratories call the test CH100). The protein was measured at less than 0.3. The normal level is 0.0-0.5 mg/dl. The anti-cardiolipin antibodies were within normal. CA19-9 was low at 6 U/mL.

A biopsy was obtained in 1999 of the small bowel muscosa, which was not diagnostic of any serious change. The architecture was normal. Inflammatory cells were not significantly increased. There was no indication of Sprue. No malignant cells were identified. No abnormalities were observed by the endoscopist.

Many tests were done and repeated in order to confirm or establish a diagnosis in this case. Unfortunately a diagnosis could not be established by the laboratory. While positive tests can help confirm a diagnosis, negative tests will not rule out that diagnosis. The diagnosis for Mr. Jeffries remains entirely a clinical one and most of the doctors who have seen the claimant have suggested it is an immunological problem. A broad term to describe Mr. Jeffries problem would be the suggestion of Dr. Michael Luggen, who called this a poly arthralgia and myalgia. Simply, this states Mr. Jeffries has multiple joint complaints and muscle complaints.

SUMMARY

Mr Eric Jeffries is a 38-year-old man who was in his usual state of good health until some time after he had received an injection of Hepatitis B vaccine. Whether this, was the cause of his subsequent illness remains to be seen. Thereafter he had multiple joint pains, severe headaches, profuse sweating, mental confusion, and generalized muscle aches. These symptoms have since waxed and waned, but most importantly, have limited his work as a bank vice-president.

I observed the 4 minutes of surveillance tape of Mr. Jeffries. I noticed he was able to drive his car and enjoy a social affair with his family. He does walk with a slow deliberate gait as if he has a pain in his low back or legs. I do not believe there is anything in this review that would contribute to the diagnosis in this case.

The medical evidence to support Mr. Jeffries impairment is entirely clinical. The diagnostic tests are not confirmative to support a diagnosis. I do not see any documentation to support a significant change in Mr. Jeffries status on or about September of 1998 when he left work. However, from the history it seems likely his pain and frustration, as well as, mental confusion

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became more embarrassing and upsetting. Finally, he decided to quit work in the hope he would improve while on temporary disability.

There is no medical documentation to support a causal relationship between his symptoms and his last diagnosis of post-vaccinal encephalomyelitis and acquired auto-immunity. This would require ad hoc (ergo: proctor hoc) reasoning, which may not be considered scientifically reasonable. I would prefer the diagnosis of acquired auto-immunity. I do not think at this time a more specific label could be applied. Diagnoses such as Behcet's, Reiter's or Crohn's are too specific to be applied, at this time. I find no discrepancies, inconsistencies, or contradictions in this record. Only, the humbling confusion of our inadequacies of defining these problems.

If I can be of further assistance, or if you have any questions please do not hesitate to write or call.

Sincerely,

Robert M. Curran, M.D., F.A.A.D.E.P.

RMC/kac